Indiana State Department of Health

	A. BUILDING		(X3) DATE SURVEY COMPLETED		
	B. WING		10/12/2012		
NAME OF PROVIDER OR SUPPLIER STREET ADDR			10/12/2012		
MAYIM HEALTHCADE SEDVICES INC		STE 100			
ED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE COMPLETE		
	N 000				
This was a home health agency State licensure survey.					
PHNS					
SN, RN					
псу	N 466				
y review, and					
	4646 W JE FORT WAY DELENCIES DED BY FULL IFORMATION)	4646 W JEFFERSON BLVD FORT WAYNE, IN 46804  ELENCIES DED BY FULL IFORMATION)  REPRESENTED NO 000  Re licensure  N 000  Re licensure  N 466  Respectively subsection ical ical files and ds, except as by: by review, and	ID PROVIDER'S PLAN OF CORRESPICE OF THE APPLICATION SHOULD FREFIX TAG CROSS-REFERENCED TO THE APPLICATION SHOULD FREFIX TAG CROSS-REFERENCED TO THE APPLICATION SHOULD FREFIX TAG CROSS-REFERENCED TO THE APPLICATION SHOULD FREFIX CROSS-REFERENCED TO THE APPLICATION SHOULD FREFIX TAG CROSS-REFERENCED TO THE APPLICATION TAG CROSS-REFERENCED TO THE APPL		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Indiana State Department of Health

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						COMIL		
		002757		B. WING				
		003757	l			10	/12/2012	
MAYIM HEALTHCARE SERVICES INC			RESS, CITY, STA					
			W JEFFERSON BLVD STE 100 T WAYNE, IN 46804					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	THE APPROPRIATE	COMPLETE DATE	
N 466	N 466 Continued From page 1			N 466				
	confidential medical records of employees were treated as confidential and maintained in separate medical files for 11 of 11 personnel files reviewed with the potential to affect all employees of the agency. (A, B, C, D, E, F, G, H, I, J, and K) Findings include:		l files oyees					
	K each contained a f II (PF2) Confidential folders contained the Tuberculosis screeni physicals, and Hepa background check a background results, payroll forms, emplo license verification for	B, C, D, E, F, G, H, I, Colder labeled "Personne Employee Information." e medical information of ings, health certificates titis B forms along with uthorization, criminal W-4 forms, miscellaneous yee status forms, driverorms, and patient list and authorization fo	el File ' The or us 's					
	the agency recently of personnel files and so contained the medical	0 PM, employee M indichanged the policy for section PF2 has always al information since the Resources (HR) position	y					
	Format," #HH-HR-01 states "4.2.1. All hea		/12, on					
N 470	410 IAC 17-12-1(m) Home health agency administration/management			N 470				
	be written and imple	Policies and procedures mented for the control case in compliance with and state laws						

Indiana State Department of Health

STATE FORM 6899 761P11 If continuation sheet 2 of 4

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		003757	003757			10	10/12/2012	
NAME OF PR	OVIDER OR SUPPLIER	1	STREET ADD	RESS, CITY, STATE	, ZIP CODE			
MAXIM HE	EALTHCARE SERVICES	SINC		FFERSON BLVD NE, IN 46804	STE 100			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
N 470	Continued From page 2			N 470				
			control sits en by  en by  a," , "3.1 g will ently l) in e not ative ash s rs."  Hand umber 2 nd					
	with body fluids or e membranes, noninta if hands are not visit	act skin, and wound dres oly soiled. H. Decontam n a contaminated-body s iring patient care. I.	ssings inate					

Indiana State Department of Health

STATE FORM 6899 761P11 If continuation sheet 3 of 4

Indiana State Department of Health

AND DIAM OF CODDECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		003757		B. WING		10/12/2012		
			STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
MAYIM HEALTHCADE SEDVICES INC				EFFERSON BLVD STE 100 AYNE, IN 46804				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		l l	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	CTION SHOULD BE COMPLE THE APPROPRIATE DATE		
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